

**SUPPLEMENT FOR NURSE MIDWIFE FOR PROFESSIONAL LIABILITY INSURANCE  
FOR SPECIFIED MEDICAL PROFESSIONS PROFESSIONAL LIABILITY**

All questions MUST be completed in full.

If space is insufficient to answer any question fully, attach a separate sheet.

1. Full name of Applicant: \_\_\_\_\_
2. Estimated number of births for the next twelve (12) months: \_\_\_\_\_
3. Name of supervising M.D. or D.O. and medical specialty: \_\_\_\_\_
4. (a) Name of facility where the Applicant practices: \_\_\_\_\_  
(b) Is the above facility either JCAHO and/or National Association of Childbirth Centers accredited? [ ] Yes [ ] No
6. Does the Applicant perform any home births? [ ] Yes [ ] No. If Yes, provide details. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**AS PART OF THIS SUPPLEMENT ATTACH THE FOLLOWING:**

- Copy of patient selection and referral Protocol under which the Applicant practices
- Copy of current American College of Nurse - Midwives certification

Signing this Supplement does not bind the Company to provide or the Applicant to purchase the insurance.

It is understand that information submitted herein becomes a part of my/our application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by the Applicant (within 60 days of the proposed effective date).

\_\_\_\_\_  
Name of Applicant

\_\_\_\_\_  
Title (Officer, partner, etc.)

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date